The Alliance of Nurse-Midwives and Maternity and Neonatal Nurses of Newfoundland and Labrador

(A Special Interest Group of the ARNN)

Newsletter - March 1993

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There is not such a long wait this time between Newsletters because I have been given information for this one. Thank you. For subsequent Newsletters I shall want further materials. This does not have to be long, a paragraph will do, on anything which you think will be of interest to our members. This can be a brief report to share with your colleagues regarding a conference which you have attended; a book which you have read; a film which you have seen; a thumb-nail sketch of a person who has contributed, or is in the process of contributing, towards the care of mothers and babies; details of future conferences or workshops; calls for abstracts; questions which you would like someone to answer; letters to the editor and comments on what is written etc. The contributor is responsible for obtaining the consent for a previously printed article to be reproduced, or for the thumb-nail sketch to be included. Thank you Kay for the report of the "National Invitational Midwifery Workshop" and thank you Pamela for the article on prenatal classes and labour from the point of view of an Australian father. Also I would like to remind members that if they change either their home or work address to please advise us so that you can continue to receive your copy of the Newsletter.

You will note that the Treasurer has changed, as from the last meeting. Kay wishes to step-down from being President. Any volunteers?

***** We need to contact <u>all</u> midwives in the province.*****
Please forward as soon as possible, the names and addresses of any midwives who are not members of the Alliance.

Have you paid your 1993 Alliance registration fee?

If you have paid for your registration you should have now received a receipt. The 1993 form for membership is at the end of the Newsletter which you can pass on to someone else.

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<u>Alliance Executive</u>

President: Kay Matthews
Secretary: Karene Tweedie
Treasurer: Clare Bessell
Publicity: Janet Murphy-Goodridge
Newsletter: Pearl Herbert

<u>Meetings</u>

<u>The Alliance Meeting</u>. There were 11 members who attended an Alliance meeting on March 17th at the home of Janet Murphy-Goodridge. A new treasurer, Clare Bessell, was elected. Thank you Dana for being treasurer for the past years and best wishes for the future. A new president is needed as Kay will start sabbatical

leave later in the year. Any nominations for others or self?

Janet Murphy-Goodridge referred to an article from the January/February 1993 issue of the RNABC News on the ethics of accepting free gifts from the various sales representatives who visit hospitals. Nurses who display pens, coffee cups, etc. bearing the company's name are indicating to others that they promote whatever the company manufactures. The week prior to this meeting there had been a report in the Globe and Mail that Women's College Hospital, Toronto, had signed a contract with Mead Johnson that in return for $1 million the hospital would promote their formula. From research it is known that mothers who are exposed to formula supplements are the ones who are most likely to stop breastfeeding in the first postpartum weeks. Janet recommended that a Resolution be given to the ARNN that health agencies be asked to control what is advertised on their premises and by their employees.

Kay Matthews advised members that a buffet reception would be held at Janette Georghiou's house to raise money by donations for the air fare of Margaret Akpaidem, a Nigerian Midwife, to attend the ICM congress in Vancouver in May. Ask Kay how to make the cheque out to obtain a receipt for income tax purposes.

Wendy Goodman then spoke on her experiences as a Clinical Nurse Specialist (CNS) at the Women's College Hospital. Maternity nurses have not yet completed the procedures to have this area of nursing recognized as a specialty by the CNA. As a CNS she does not belong to a union and therefore there is no safeguard of her job description, hours of work, salary, and the tasks that she can be asked to perform. She has no defined role. She also discussed the hospital's breastfeeding practices and the politics behind the formula contract, with which many at the hospital disagree.

The Nurse-Midwifery Association of the Alliance held a meeting on March 1st, 1993. There were 7 members present, and 3 apologies from other members. The ARNN Council was meeting on March 16th when they would consider the report of the Ad Hoc Midwifery Committee. Kay Matthews is a member of the Provincial Committee considering midwifery. Short term goals were discussed and the main one is to contact all midwives in the province. Education of both nurses and the general public as to what is midwifery. Considerations were given to International Midwives Day which occurs the first weekend in May, and to ask if there can be a poster displayed at the Canadian Public Health Association conference in St. John's in July. Kay Matthews is investigating ways of raising money for the Nigerian midwife to attend the ICM congress in Vancouver in May. So far Kay has found how a receipt for income tax purposes can be given for the money received, and a buffet is being explored to which people can be invited and at the same time make a money donation. This will be raised again at the next Alliance meeting. The next Nurse-Midwifery Association meeting to be two weeks after the Alliance Meeting.

The situation of Midwifery across Canada: B.C. had an inquiry on January 25th and it could take up to six months for the results to be known. The RNABC submitted that they agree with the

international definition of a midwife, and that they would register nurse-midwives and the BC Midwifery Association could register other midwives. The Midwifery Association disagrees with this as it would fragment midwifery and be similar to what has happened in the U.S., and they were told that they had made a good presentation. Alberta - legislation was passed in July 1992 for midwifery to be autonomous (a self directed profession in its own right). At present the midwives are getting everything organized in time for the day when the Act is proclaimed. Saskatchewan - no up to date news although they were waiting to see what happened in Alberta. Manitoba - After the executives of the Manitoba Association of Registered Nurses and the Medical Association compiled a report which was criticized as having no input from others, the government instituted a task force to study midwifery. Ontario - Legislation was passed in November 1991 for midwifery to be legalized as an autonomous profession under the Regulated Health Professions Act. The proclamation day is set for the Fall of 1993. The government-appointed Interim Regulatory Council on Midwifery to prepare for the practice of midwifery, standards, education, etc. etc. finished in January 1993 and is now replaced by the Transitional Council of the Ontario College of Midwives funded by the Professional Relations Branch of the Ministry of Health. The priority of this new Council is to complete the regulations of the Midwifery Act, and to design registration procedures. The proposal submitted for the "Credentialling of Midwives in Ontario Hospitals" was approved in January 1993. The once only preregistration program to prepare midwives to register, commenced last autumn at the Michener College in Toronto, and the midwives taking part are those who have their own practice which they can use to demonstrate their skills. Commencing next September is the baccalaureate midwifery degree programme at McMaster University in collaboration with the Laurentian University and Ryerson Polytechnical Institute. Midwives from other countries and provinces must possess the equivalent to the Ontario baccalaureate degree in midwifery in order to apply for registration. Midwives must be competent in hospitals, birth centres, and homes, as the woman has the choice of place of birth. Quebec - Although Bill 4 considered nurse-midwives in the eight projects across the province, it has now been agreed that all midwives can apply to be considered. They have to pass a written examination, which has been held, and the practical examination which is at the end of April. Those who do not pass the examinations are individually considered and advised as to the further preparation which they require. The programme to prepare Inuit midwives continues in Povungnituk. Nova Scotia - The Registered Nurses Association of Nova Scotia is considering nurse-midwives, and the Midwifery Association is considering autonomous midwifery. A pilot project is being considered. New Brunswick and PEI do not appear to be considering midwifery. There is no current news from the two Territories. Newfoundland - From the replies received from nurses in the province the ARNN council has decided that midwifery should be <u>under</u> nursing, unlike the other provinces (and European countries) where midwifery is considered to be a

discipline in its own right. There is a provincial government committee studying midwifery. The Nurse-Midwifery programme is still in the calendar for Memorial University. The names of all midwives in the province are needed, regardless of where they trained, whether they are nurses, working, retired, unemployed.

National Invitational Midwifery Workshop on Research and Evaluation: McMaster University, Hamilton. November 13 to 15, 1992. Submitted by Kay Matthews.

As President of the Alliance, I was invited to attend the above conference which was organized by Karyn Kaufman at McMaster University, and funded by a conference grant from the National Health Research and Development Program (NHRDP) of Health and Welfare Canada. Representatives from each provincial Midwifery Association, key representatives from the provincial Departments of Health (Ruth Graham represented Newfoundland), and researchers, were the participants.

On Friday afternoon, presentations describing midwifery practice in the Netherlands, Denmark, and Australia, were given by midwives from these countries. Later, each provincial representative gave a brief update on the status of midwifery in their province. P.E.I. and New Brunswick were the only provinces not represented. Canadian midwifery models were presented next. The Toronto Midwives Collective described the number of home births they had conducted in the Toronto area (at least 1800 now in total), the number of pregnancy visits to each mother (12), the average number of hours spent with the mother in labour (12), and number of postpartum visits (5). Their statistics were impressive. The nurse-midwifery pilot projects in Calgary and Vancouver were presented. These are both hospital-based and there are problems because they are short-term projects and may not be funded once the project is completed. There is a lot of role strain as they are having to "prove" themselves. "Burnout" was mentioned as a problem. The Povungnituk project in northwest Quebec was described and they have an excellent program to keep their low-risk mothers in the community for birth. Mothers with complications are sent south to the tertiary care centre. Their statistics are impressive and an important feature of this program is the integration of the aboriginal midwife into the health care system.

The following day we were divided into working groups. Each group had a mixture of midwife, government and researcher. The group task was to discuss how midwifery should, could, be implemented and evaluated. However, each group had to focus on a selected number of questions. A group recorder was appointed. In the afternoon we tackled a different set of questions. It was a challenging day!

On Sunday, the group recorders summarized the main discussion points on flip-board papers which were displayed around all the walls and a report was given by each group leader. The conference ended with presentations by Holiday Tyson (Direct-Entry midwife trained in Britain) on the statistics from the Toronto Woman's Collective. These were the basis for her Masters degree in

epidemiology. Another presentation was made by researchers from the faculty of Health Sciences at McMaster which stressed the importance of the randomized controlled trials to evaluate the practice of midwifery. Another big issue was cost-effectiveness. One participant asked why was midwifery being so rigorously examined when the practice of medicine had never had the same examination.

All in all it was a very interesting conference. What is clear is that each province will have the model best suited to that province's needs. The new midwifery programs in Canada will be baccalaureate and direct entry (shortly after the conference, McMaster was awarded the first midwifery baccalaureate program in Canada). Midwives MUST BECOME POLITICALLY AWARE AND ACTIVE. THERE IS A RISK THAT MIDWIVES WHO ARE NURSES MAY NOT GET DUE RECOGNITION IF THEY DO NOT STAND UP FOR THEIR PROFESSIONAL ROLE AS MIDWIVES.

Trends in Obstetrics. An inservice workshop of the S.A. Grace General Hospital, held on March 17th, repeated March 18th, 1993, at the Hotel Newfoundland, St. John's. Submitted by Pearl Herbert.

Wendy Goodman, BN, MEd (Adult education), a clinical nurse specialist at the Woman's College Hospital, Toronto, spoke on "Family Centered Maternity Care" and referred to the Family-Centred Maternity and Newborn Care National Guidelines (1987) by Health and Welfare Canada, and the two volumes of Effective Care in Pregnancy and Childbirth (1989) edited by Chalmers, Enkin, & Keirse. The presentation started with a Monty Python film, a satire of the medicalisation of childbirth and the mother not having the experience to know what is best. The points made were that childbearing families have needs beyond safe birth, and they want to be in control. Birth is a normal healthy process that provides an opportunity for growth and the use of procedures should be based on research. Families should actively participate in the care that they receive, and be able to make informed choices. Childbearing families have differing expectations of the care which they require and so those providing care need to be flexible.

On Wednesday, Dr. Sinave spoke on "HIV/AIDS". (Dr. Bowmer spoke the following day). Newfoundland has fewer patients with AIDS but also has a smaller population than British Columbia, Ontario, or Quebec. Dr. Sinave described the differences between culturing bacteria and viruses. The blood specimens are sent to the Health Sciences Centre for testing for the CD4 cells, but these do not last long outside of the body and so the person is required to visit the laboratory. People do not die from AIDS but from the infections to which they are vulnerable. AZT has been found to be teratogenic in animals. The GSF drug is expensive and if used for treatment costs about $45,000 per month. Most studies have male subjects as women who become pregnant have to be dropped from the study. It has been scientifically found that there is no difference between the rate that the disease progresses in males and in females. In African and Asian countries HIV is an heterosexual disease, while in North American and European countries there are more males than females infected; although in Newfoundland this is

reversed. An epidemiological survey using blood from pregnant women was carried out in Newfoundland but HIV positive women may not become pregnant, and of course men were excluded. Mothers can infect their baby from early in pregnancy until after birth. A French study found no difference in the infection rate if a baby was born by cesarean section or if a baby was born vaginally (New England Journal of Medicine). It is difficult to diagnose HIV in the neonate as all newborn babies have antibodies from their mothers but this does not mean that they have an infection. Infections produce antigens and so these are looked for. AZT can be given to very young babies. Babies with HIV do not live very long and will probably die in the first six months of life. Older children who become infected with HIV will live for several years before they develop AIDS.

Wendy Goodman spoke on "Breastfeeding". Canada is a bottle feeding country and Newfoundland has the lowest breastfeeding rate in the country. She also stated that many did not agree with the Women's College Hospital signing the contract with Mead Johnson but the Hospital Board voted for the contract by a small margin.

Dr. Windrim, obstetrician at the S.A. Grace General Hospital, spoke on "Emergency Delivery". At this hospital only doctors are allowed to do an episiotomy. He discussed shoulder dystocia and referred to the film in the HSC Library made at The Farm, near Summertown, Tennessee. [Also see the book Spiritual Midwifery, by Ina May Gaskin, regarding the Farm and births]. He discussed fetal distress, postpartum haemorrhage, prolapsed uterus, and the films of Margaret Myles' 1976 workshop with our Association. (These unedited videos are in the HSC Library).

Dr. Peachy, 4th year anaesthetist resident, gave a very informative talk, illustrated by slides, on "Epidurals and Regional Anaesthetics" including the indications and contra-indications for these. The drugs used, spinal versus epidural techniques, and complications which could occur. The preparation of the woman, monitoring of her condition into the postpartum period, and medical/legal aspects were all discussed.

Workshops

The COGNN 4th National Conference - "Powerful Partnerships: Women and Health Policy". May 13 to 15, 1993, at the Radisson Hotel, Ottawa. Members $165.00, non-members $200.00 payable by May 1st. Information from Donna Sharpe, 116 Thornton Avenue, London, Ontario N5Y 2Y5.
(From January 1st the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) is the new name for the former NACOG).

A father's look at prenatal classes and childbirth is given in the following:

The Delivery Suite Blues. Pamela Browne submitted this article which had previously been written in the CEA Newsletter, Darwin, New Territories, Australia.

Entire books have been written about the pain of childbirth. But who has it worse - the mother? Or the father who has to watch?

Let us take a quick look at the history of baby-having.

For thousands of years, only women had babies. Primitive women would go off into primitive huts, and groan, and wail, and sweat, while other women hovered around. The primitive men stayed outside doing manly things, such as lifting heavy objects and spitting.

When the child was born, the women would clean it up as best they could and show it to the men, who would spit appreciatively, and head off to the forest to throw sharp sticks at small animals. If you had suggested to primitive men that they should actually watch women have babies, they would have laughed at you, and probably tortured you for three or four days. They were real men.

At the beginning of the 20th century, women started having babies in hospitals. Often males were present, but they were professional doctors who were paid large sums of money and wore masks. Normal males continued to stay out of the baby-having area; they remained in waiting rooms reading old copies of Field and Stream, an activity that is less manly than lifting heavy objects but still reasonably manly.

What I am getting at is that, for most of history, baby-having was mainly in the hands (so to speak) of women. Many fine people were born under this system. Charles Lindberg, for example.

Things changed, though, in the 1970's. The birth rate dropped sharply. Women started going to college, and driving bulldozers, and carrying briefcases, and using words like debenture. They just did not have time to have babies. But young professional couples began to realize that their lives were missing something - a sense of stability, a companionship, or responsibility for another life. So they got Labrador retrievers. Then they started having babies again, mainly because of the tax advantages. These days you can not open your car door without hitting a pregnant women. But there is a catch; women now expect men to watch them having babies. This is called "natural-childbirth", which is one of those terms that sound terrific but that nobody really understands, such as "pH balance".

At first natural-childbirth was popular only with hippie-type, granola-oriented couples who lived in geodesic domes and named their babies things like Peace Love World Understanding Harrington-Schwartz. The males, their brains corroded by drugs and organic food, wrote swarmy articles about "What A Meaningful Experience It Is To See A New Life Come Into The World". None of these articles mentioned the various other fluids and solids that come into the world with the new life, so people got the impression that watching someone have a baby was just a pack of meaningful fun. Wherever you turned you would run into natural-childbirth converts who would drone on for hours, giving you a contraction by contraction account of what went on in the delivery room. They were worse than moonies, or people who tell you how much they bought their houses for in 1973 and how much the houses are worth today. Before long, natural-childbirth was everywhere, like salad bars. Now, perfectly innocent males all over the country are watching females have babies. I recently had to watch my wife have a baby in our local suburban hospital.

First, we had to go to 10 evening childbirth classes at the

hospital. The hospital told us, mysteriously, to bring two pillows. This was the first humiliation because no two of our pillowcases match and many have cranberry juice stains. It may be possible to walk down the streets of Kuala Lumpar with stained, unmatched pillowcases and still feel dignified, but this is not possible in suburbia. Anyway, we showed up for the first class, along with about 15 other couples consisting of women who were going to have babies and men who were going to watch them. They all had matching pillowcases. In fact, some couples had obviously purchased theirs especially for childbirth classes; those were the swank couples, who were planning to have wealthy babies. They sat together through all the classes and eventually agreed to get together for brunch.

The classes consisted of sitting in a brightly lit room and openly discussing, among other things, the uterus. We also looked at lots of pictures. One evening we saw a movie of women we did not even know having a baby. I am serious. And another time, the instructor announced, in the tone of voice you might use to tell people that they have just won free trips of the Bahamas, that we were going to see colour slides of a cesarean section. The first slides showed a pregnant woman cheerfully entering the hospital. The last slides showed her cheerfully holding a baby. The middle slides showed how they got the baby out of the cheerful women, but I can not give you a lot of detail here because I had to go out for 15-20 glasses of water. I do remember at one point our instructor cheerfully observed that there was "surprisingly little blood, really". She evidently felt this was a real selling point.

When we were not looking at pictures or discussing the uterus, we practised breathing. This is where the pillows came in. What happens is that when the baby gets ready to leave the uterus, the woman goes through a series of what the medical community refer to as "contractions"; if it referred to them as "horrible pains that make you wonder why you ever decided to get pregnant" people might stop having babies and the medical community would have to go into the major-appliance business. It was not so long ago that doctors avoided the contraction problems by giving lots of drugs to women who were having babies. They would knock them out during the delivery, and the women would wake up when their kids were starting school. But the idea with natural-childbirth is to avoid giving the women a lot of drugs so that she can share the first, intimate moments after birth with the baby, and the father, and the obstetrician, and the paediatrician, and the standby anaesthetist, and several nurses, and the person who cleans the delivery room. The key to avoiding drugs, according to the natural-childbirth people, is for the woman to breath deeply. Really. The theory is that if she breathes deeply, she will get all relaxed and will not notice that she is in a hospital delivery room wearing a truly perverted garment and having a baby. I am not sure who came up with the theory. Whoever it was evidently believed that women have very small brains. So, in childbirth classes, we spent a lot of time sprawled out on little mats with our pillows while the women pretended to have contractions and the men squatted around with stop-watches and pretended to time them. The swank coupled did not

care for this part. They were not into squatting! After a couple of classes, they started bringing little backgammon sets and playing backgammon when they were supposed to be practising breathing. I imagine they had a rough time in actual childbirth. Anyway, my wife and I trained along for months, breathing and timing, respectively. We had no problems whatsoever. We were a terrific team. We had a swell time. Really.

The actual delivery was slightly more difficult. I do not want to name names, but I held up my end. I had my stopwatch in good working order, and I told my wife to breathe. "Don't forget to breathe", I would say, or "You should breathe, you know". She, on the other hand, was unusually cranky. For example, she did not want me to use my stopwatch. Can you imagine? All that practise, all that squatting on the natural-childbirth classroom floor, and she suddenly gets in this big snit about stopwatches. Also, she completely lost her sense of humour. At one point, I made an especially amusing remark, and she tried to hit me. She usually has an excellent sense of humour. Nonetheless, the baby came out alright, or at least alright for newborn babies, which is actually pretty awful unless you are a big fan of slime. I thought I held up well for the whole thing when the doctor, who up until then had behaved like a perfectly rational person, said, "Would you like to see the placenta?" Now let us fact it. That is like asking, "Would you like me to pour hot tar into your nostrils?" Nobody would like to see a placenta. If anything, it would be a form of punishment.

JURY: We find the defendant guilty of stealing from the old and the crippled.

JUDGE: I sentence the defendant to look at three placentas.

But without waiting for an answer, the doctor held up the placenta, not unlike the way you might hold up a bowling trophy. I bet he would not have tried that with people who had matching pillowcases.

The placenta aside, everything worked out fine. We ended up with an extremely healthy, organic, natural baby, who immediately demanded to be put back into the uterus.

♪♫♪ **HAPPY EASTER** ♪♫♪

Globe and Mail, March 5, 1993

Hospital signs formula contract

Firm to give $1-million

BY CRAIG McINNES
The Globe and Mail

TORONTO — A prestigious Toronto teaching hospital has given an infant-formula manufacturer an exclusive contract for the next 10 years in return for a $1-million grant.

The agreement between Women's College Hospital and Mead Johnson Canada is the latest in a number of controversial agreements in Canada that some breast-feeding advocates allege contravene a World Health Organization code restricting the marketing of infant formula.

Robert Haslam, president of the Canadian Pediatric Society, sharply criticized the deal. "I've looked upon the Women's College Hospital as a hospital that has prided itself on the commitment to maternal and infant health and I now have to bring that into question," Dr. Haslam said. "They've sold their soul to the company store."

The agreement, which was announced yesterday by the hospital, will give it $1-million toward a $7.5-million renovation of its perinatal unit. In addition, Mead Johnson is giving the hospital an annual grant of $35,000 for a hot line for breast-feeding mothers.

In return, the company gets access to new mothers who have decided not to breast-feed their children. Mead Johnson, which produces Enfalac as well as specialty formulas, will supply free all the formula used at the hospital. Most parents continue giving their children the brand of infant formula that they first get in the hospital where they were born.

The Canadian Medical Association has condemned the practice of manufacturers providing free formula to hospitals.

The medical advisory committee of Women's College Hospital opposed an earlier draft of the agreement with Mead Johnson, but hospital president William MacLeod said he had polled the committee before the amended agreement was signed and the majority approved it, although no formal vote was taken.

Women's College Hospital makes deal with formula firm

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Dr. Haslam, who wrote to the hospital earlier arguing against the agreement, said that by taking the money the institution is giving its implicit approval to bottle-feeding, which is not as good for babies as breast-feeding in most cases.

"I think that any hospital that is going to get into bed with a formulary company, for whatever sum of money it is, is saying that formula is okay."

Mr. MacLeod defended the agreement, saying the number of mothers who are breast-feeding their babies after leaving the hospital has actually increased since it started accepting money from Mead Johnson three years ago under a previous agreement.

"The funding we've received from Mead Johnson has been helpful."

The relationship between hospitals and formula manufacturers in Canada has been highly controversial since the adoption of the WHO code in 1981. The code was aimed at preventing formula companies from persuading mothers, particularly in developing countries where getting clean water is a problem, to use their products instead of breast-feeding.

Hospitals and formula companies in Canada deny that their contracts contravene the spirit of the code, but critics argue that the companies would not be putting up the money if they were not getting something for it.

"The company is buying the right to compete with women's breasts," said Elisabeth Sterken, national director of Infact Canada, a group that has been fighting the issue for years.

"Mead Johnson is not giving them a million dollars for a charitable purpose," she argued. "They are buying a piece of the infant-formula market."

David MacMartin of Mead Johnson said his company subscribes to the WHO code and the principle that breast-feeding is the preferred method.

"The WHO code doesn't prohibit the making of formula available to mothers; it has to be done in a context of support for breast-feeding as a preferred method and that mothers make a decision based on the advice of a health professional.

"The reality of the matter is that some mothers choose to formula-feed or to breast-feed for a period of time and then to wean their babies, because they have to go back to work."

Kyle Rae, a member of the hospital's board of directors who opposed the deal, said such deals have become inevitable because of the continuing funding crises faced by so many institutions.

"I don't agree with what we've done, but I think it's a sign of the times," Mr. Rae said. "It's happening to all the hospitals; they are against the wall."

Women's College Hospital is in fairly good financial shape compared with many hospitals, but Mr. MacLeod said all such institutions are going to have to be looking for new sources of revenue as government money dries up.

"We're looking for those kind of win-win relationships where we don't impinge on the clinical care that we provide but we provide a service or role to other business organizations as part of the general service we're providing."